DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/09/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 09G211 07/05/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) {W 000} INITIAL COMMENTS {W 000} This recertification survey was conducted from May 22, through May 24, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the conditions level of participation of client protection and active treatment. Based on the findings of the extended survey a full survey was implemented to review governing body and staffing. A random sample of three clients was initially selected from a residential population of six females. An additional client was added to the sample as a focus. All clients in the sample had diagnoses of profound mental retardation. One of the six clients was blind. Three clients in the facility had psychiatric diagnoses for which medications were prescribed. The clients in this facility had limited to no skills in verbal communications. The findings of this survey were based on observations at the facility and day programs ,staff interviews at both the facility and day programs, review of clinical, medical, and administrative records to include the facility's unusual incident reports and policies. As a result of the survey findings it was determined that the facility was not in compliance at the Condition Level of Participation under Client Protection

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTANVES SIGNATURE
TITLE
(X6) DATE

The HRDI Inc., Intermediate Care Facility is in compliance with 42 CFR Part 483, Subpart 1,

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM CMS-2567(02-99) Previous Versions Obsolete

health and safety.

The findings include:

Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's

1. Clients #1, #2, #3 and #4 have several new

consultants that started in January 2007. There

was no evidence that the consultants who signed

contracts had reviewed the needs of the clients or

Event ID: IJBB12

Facility ID: 09G211

quarterly/ as needed basis.

W159

QMRP has received assessments from consultants

Speech, OT, PT Nutrition and Psychologist regarding

Individual Program Plan goals to provide ongoing

active treatment to clients. QMRP has been in-serviced

on obtaining assessments for clients from consultants and having consultants review client needs on a

If continuation sheet Page 2 of 16

7/19/07 &

Ongoing

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7. The QMRP failed to ensure that the clients

and functional for use. [See W436]

recommended equipment had been maintained

8. Following the dinner meal observed on May

22, 2007 at approximately 6:20 PM, client #2 was

observed to put saliva and chewed food particles

in her hand and rub it across her hair and on

(W436)

7/19/07 &

Ongoing

QMRP has consulted with guardians of individuals to

obtain written informed consent concerning the use of

restrictive techniques: Behavior Support Plan,

psychotropic medications, etc. Those clients that have restrictive techniques incorporated into their IPP will

have consents signed annually at their ISP meetings

whereby the IDT can explain risks, benefits, etc. to

guardians/family members concerning these techniques.

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and enhance skills.

behavior 21 times from May 1 to May 22, 2007.

9. Refer to W255 and W257. The QMRP failed to

ensure consistent opporutnities for clients to learn

10. Refer to W249. The QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with

their individual program plans (IPPs).

determined

QMRP has been in-serviced on IPP development and

will ensure that all clients ISP/IPP will begin as soon as

active treatment is continuous and needed program

interventions are implemented immediately.

by the IDT (at time of ISP) such that

7/5/07 &

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{W 159}	10. The Qualified I Professional (QMR programs included implementation. Reserved as a seed on observative review, the facility (Professional (QMR)	Mental Retardation P) failed to ensure that training methodology for staff efer to W234 ion, staff interview and record Qualified Mental Retardation (P), failed to adequately and coordinate each client's	{W 1		(W436) QMRP has been in-serviced on the ma		
{W 249}	ensure that the clie had been maintain 2. Cross refer to Wensure that clients opportunities for conscordance with the (IPPs). 483.440(d)(1) PROMAS soon as the interfermulated a client each client must retreatment program interventions and sand frequency to s	436. The QMRP failed to ents recommended equipment ed and functional for use. 249. The QMRP failed to were provided the entinuous active treatment in eir individual program plans. OGRAM IMPLEMENTATION Perdisciplinary team has a individual program plan, eceive a continuous active consisting of needed ervices in sufficient number support the achievement of the d in the individual program	{W 2	2.	upkeep of all client adaptive equipment. will be daily adaptive equipment ch completed by staff and management to et equipment is in good repair. All sta manager have been trained on completing equipment Checklist which is filed in record with their individualized adapti listed on the form. (W249) ISP/IPP will begin as soon as determined	As well there lecklist to be insure adaptive aff and home g the Adaptive in each clients we equipment by the IDT (at	7/19/07 & Ongoing

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 07/09/2007 APPROVED : 0938-0391
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HRDI OF	THE DISTRICT OF C	OLUMBIA, LLC		;	8073 VISTA STREET, NE WASHINGTON, DC 20018		
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(W 249)	This STANDARD is	s not met as evidenced by:	{W 2	49}			
	review, the facility facility facility for were provided the control of the contr	on, staff interviews and record alled to ensure that clients opportunities for continuous accordance with their plans (IPPs).					
	The findings include:						
		documentation, and clinical ved on May 24, 2007 at 11:40					
	program that read " language skills by u the opportunities wi of snack times were 2007 at approximat dinner meal on May	#2's IPP, the client had a will improve expressive sing the sign eat for 80% of th hand/hand. Observations a made on May 22, and 23, ely 4:15 PM each day and a 22, 2007 at approximately re no attempts observed to in eat at the given			(W249) 1. Client #2 has received Speech assessmen need for a communication goal. Home Manager and QMRP have be communication goal for Client #2 appropriate times (during mealtime). QMRP/SLP will ensure staff are t quarterly on communication goals. 2. Client #2's IPP goals and objectives have reflect activities that engage her in se activities. Staff have been in-sectional staff and the stimulatory activities that engage her stimulatory activ	Direct care streen in-serviced to sign "eat" As an assurar rained/in-service been revised insory stimulate serviced on s	aff, on 7/5/07 at ace ced to orry
	2007, client #2 was impaired. The House client #2 was blind. included on the Med	vation period on May 22, observed to be visually se Manager confirmed that This diagnosis was also dical assessment dated at was reviewed on May 22,			stimulatory activities that engage her indulge her senses besides sight as impaired.		
	2007 that was revier PM reflected that the to participate in sense.	ssessment dated January wed on May 23, 2007 at 3:45 e client should be encouraged sory activities including sound, ch. Further stated was the "it					

would be helpful to tailor activities around her

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLÉ CONSTRUCTION	(X3) DATE SUI COMPLET	
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(W 249)	on May 23, 2007 a indicated that sens the facility. The eq sensi- ball switch, was switch, oval tax muniform of inoperable perhaps. Although music plasitting out on their sensory motor functing out on their sensory motor functing the observation. It client #2 had been sensory task/activity. Client #2's IPP 24, 2007 at approximate approximate in an action of the client had perform the client had perform the client had perform top of her plate offered or attemptodes.	at 4:03 AM, the House Manager ory motor equipment was in uipment shown included a vibrating mini bubbles, gooshy alti sensory, and high music device. These items were is due to having no batteries. Any and while all clients were porch, this was the only ctioning activity provided during could not be determined that engaged in the multiple ties as recommended. And data was reviewed on May simately 11:00 AM. In objective which read "will etivity with her peers or staff nice". The focus of the iffied to be "setting the table". Or dinner meal or the snack	{W 2	49}	QMRP has revised Client #2's goal which participate in an activity with peers or state assistance" to reflect that Client#2 actually an activity with peers as a socialization goal (an activity to participate in of her choice). b) QMRP has in-serviced direct care staff in on all clients IPP goals and objectives. Clien "stack utensils on top of her plate" will be during natural opportunities such that the goal is implemented.	ff with verbal engages in (i.e. choose the facility at #2's goal conducted	7/5/07 & ongoing
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING R B, WING 09G211 07/05/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {W 249} Continued From page 7 {W 249} Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). The finding includes: On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Client #2 had been engaged in the multiple sensory task/activities as recommended by the psychologist. 483.460(a)(3) PHYSICIAN SERVICES {W 322} {W 322} The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample. The finding includes:

1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment dated September 19,

2006 reflected the following medical

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	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	30 W IX	EET ADDRESS, CITY, STATE, ZIP CODE 173 VISTA STREET, NE /ASHINGTON, DC 20018 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 322}	recommendation timely as evidence a. According to a 11, 2006, client # obtained for the callow brushing of reflected that if the procedure wo to this examination attempted March unsuccessful. The August 16, 2006 "annual exam, patime of the survey and the physician to the results in formation of the survey and the physician to the results in formation of the survey of the annual done. The survey discussed the ap 11:30 AM, the RN client #1 was not clients received to LPN was told than ammogram. The time of survey the time of survey the facility failed a timely diagnost recommended. If acility medical st examinations and c. According to the commended of the commen	procedures were not completed	{W}	22}	(W322) 1) a) Nurse has obtained results from Cliet consultation held on July 11, 2006. The ensure that all results are obtained from coatimely manner. b) The facility Nurse has scheduled mammogram for June 11, 2007 and will erecommended consultations are conduct specific timeframe which does not interclient's health, safety and welfare. c) Nurse has been in-serviced on provide follow-up care to all clients in the home Client #1 has been scheduled for follow ENT/ BSER evaluation. d) Nurse has been in-serviced on providing and making required notations per reconsultations. EKG results for Client #1 obtained and notations made in Client record. As a practice, HRDI Nurse's wirecord keeping is maintained and client results and any follow-up recommendations.	client#1 for ensure that all ted within a fere with the ding adequate e specifically way up visit for ing follow-up recommended the have been #1's medical ill ensure that ecords reflect	7/11/07 & annually 7/11/07 & annually 7/5/07 & Ongoing 7/5/07 & Ongoing

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foods in a fast pace.

follow. The surveyor and the RN attempted to locate the results of the EKG on May 25, 2007 at 11:53 AM. The report was not available at the facility. There were no follow up notations about the EKG identified in the following months of

2. The facility failed to provide safe techniques to

a). Client #1 was observed having dinner on May

22, 2007 at approximately 6:08 PM. The surveyor

fifteen to twenty seconds, client #1 had consumed

was standing approximately twelve inches from

the table where all clients were seated. Within

all of her food. There was no intervention

encourage clients #1 and #3 from consuming

summaries by the primary physician.

client's needs.

client's needs.

7/16/07 &

7/16/07 &

Ongoing

Ongoing

a) Direct care staff have been in-serviced on eating paces for Client #1 per the SLP instructional plan for slowing her eating pace. Eating Guidelines have been

developed for clients in the home. QMRP will ensure

that SLP and Nutritionist conduct quarterly reviews to

ensure that eating guidelines/protocols address the

b) Direct care staff have been in-serviced on eating

paces for Client #3 per the SLP instructional plan for

slowing her eating pace. Eating Guidelines have been

developed for clients in the home. QMRP will ensure

that SLP and Nutritionist conduct quarterly reviews to ensure that eating guidelines/protocols address the

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NAME OF PROVIDER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC			30	REET ADDRESS, CITY, STATE, ZIP CODE 073 VISTA STREET, NE VASHINGTON, DC 20018			
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{W 322}	An interview with of staff was conducted AM. This interview capable of eating client was monitor was also prescribed. On May 23, 2007 surveyor inquired guidelines for eating A speech report of reviewed on May report reflected "higuidelines to proma report noted by spreflected "follow eating the speech therapolient #1's training attached slow eating attached slow eating pace had be formal and consist choking. b). During observed the staff superview the staff superview the staff superview the staff #1 on the 7:15 PM indicated and has to be proceed to the staff was to the staff was to the staff was to the proceed to the staff was to the staff was to the proceed to the staff was to th	client #1's lead day program ed on May 22, 2007 at 11:20 or revealed that client #1 was independently; however, the ed to slow down. The client ed a chopped diet. at approximately 9:00 AM, the as to rather client #1 had anying as part of her meal plan. ated November 13, 2006 was 23, 2006 at 9:00 AM. This ome should continue to use note slow eating rate". Another each and dated June 8, 2006 ating and texture guidelines per oist. A document identified in a book reflected "pace by using ing rate protocol". There was col. termined that client #1's rapid been addressed through a stent protocol to prevent possible ovations of the the dinner meal y 22, 2007 beginning at 6:24 is observed eating her dinner was observed eating very rapidly rised the table. Interview with the same day at approximately dithat Client #3 eats very fast ompted to slow down.	{W 3	322}			
	Review of the Sp	eech and Language Assessment					

REGULATORY DR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE PATE (W 322) Continued From page 11 dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist. Note: The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy. Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample (Client #1 and Client #3) The finding includes: 1. Interview with the Licensed Practical Nyrse	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
NAME OF PROVIDER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC (X4) ID SUMMANY STATEMENT OF RECIRCINES (X5) ID SUMMANY STATEMENT OF RECIRCINES (X6) ID SUMMANY STATEMENT OF RECIRCINES (X7) ID SUMMANY STATEMENT OF RECIRCINES (X7) ID SUMMANY STATEMENT OF RECIRCINES (X8) ID SUMMANY STATEMENT OF RECIRCINES (X9) ID S								
HRDI OF THE DISTRICT OF COLUMBIA, LLC XXI) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO REPORT OF DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO REPORTIVE ACTION SHOULD BE DEFICIENCY OR LSC IDENTIFYING INFORMATION TAG W 322 Continued From page 11 dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace, as the can utilize an acceleration eating pace at times." Further review of Client #3 shufritional Assessment dated 12/3/06 on the same day at approximately 11.25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12.30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist. Note: The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy. Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample (Client #1 and Client #3) The finding includes: 1. Interview with the Licensed Practical Nyrse			09G211					
MASHINGTON, DC 20018 MASHINGTON, DC 20018	NAME OF P	ROVIDER OR SUPPLIER		_	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
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dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration. Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist. Note: The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy. Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample. (Client #1 and Client # 3) The finding includes: 1. Interview with the Licensed Practical Nurse	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	-IX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE	COMPLETION
(LPN) on June 5, 2007, at approximately 1:45 PM revealed that the results of Client #1's annual pap	{W 322}	dated 11/13/06 on a feeding/swallowir indicated that "staff Client #3 by adhericating pace, as she eating pace at time #3's Nutritional Assisame day at approunder the "Nutrition aspiration. Review of the in seapproximately 12:3 been trained on as no evidence that trafacility failed to folk protocol as recompliant and page Pathology 19:2006 reflected hypertension and his breast, left breast research to ensure medical care through timely for two of three clies (Client #1 and Clies). Interview with the (LPN) on June 5, 2	5/23/07 at 11:12 AM revealed in protocol. The protocol is should continue to provide for ing to the attached form to slow e can utilize an acceleration is: "Further review of Client is essment dated 12/8/06 on the eximately 11:25 AM revealed in Conditions" Potential for a conditions are evice training log on 5/24/07 at 60 PM revealed that staff had piration on 5/17/06. There was aining was effective. The bowed the feeding/swallowing mended by the Speech and gist. If assessment date September diagnoses to include history of carcinoma of left mastectomy. The coord review, the facility failed preventive and general medical of appointments and follow upents in the primary sample. In the primary sample in the primary sample in the primary sample.	{W :	322}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		09G211	B. WING	3	· · · · · · · · · · · · · · · · · · ·	07/05	
	ROVIDER OR SUPPLIER	OLUMBIA, LLC		3073	ADDRESS, CITY, STATE, ZIP CODE VISTA STREET, NE HINGTON, DC 20018		
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{W 342}	There was no docu facility had obtained 2. Interview with the (LPN) on June 5, 20 revealed that Direct provided training in symptoms of aspirated documented evider provided training in symptoms of aspirated 483.460(c)(5)(iii) NI Nursing services mother members of tappropriate protect measures that inclutraining direct care symptoms of illness accidents or illness meet the health need. This STANDARD is Based on observation of training records the failed to ensure that provided training in symptoms of illness clients in the sample. The finding included Client #1 was obseined to the control of the con	, 2006 had not been obtained. mented evidence that the I the client's pap exam results. It can be compared to the client of the signs and client of the cl	{W 34		42) LPN/Nurse has obtained Client #1 conducted on June 11, 2006. Nurse serviced on obtaining results from examin a timely manner. LPN/Nurse Coordinator has in-serviced care staff in the facility on signs and illness (i.e. aspiration, Health Managem As well, Quality Improvement specialismonthly trainings which include Signs	has been in- s/ consultations viced all direct 1 symptoms of ent Care Plan). st will conduct	7/5/07 7/5/07 & Ongoing
		clients were seated. Within conds, client #1 had consumed			of illness such that direct care staff of trainings to ensure comprehension of trainings to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROMOBER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC STETET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE WASHINGTON, DC. 20018 PREMENT (EACH DEPROEMEN VINUS IN FERRICIDED BY FULL PREMENT TAG WASHINGTON, DC. 20018 PROMOBER PLAN OF CORRECTION PROMENT TAG PREMENT ACTION PROPRIET (EACH DEPROMENT WINS INFORMATION) TAG CONSTRUCTION PROPRIET Based on staff performance during the dinner meal, it could not be determined that the direct care staff, overseeing client #1's meal, had been trained to address client #1's rapid eating pace and potential for aspiration. The training record reviewed on May 24, 2007 at approximately 11:30 PM reflected that out of nine direct care staff had received training on May 17, 2006 on detection of signs and symptoms of aspiration. There were no current trained direct care staff had been provided training in detecting signs and symptoms of filmes or dysfunction for two of three clients in the primary sample. (Client #1 and Client #3) The finding includes: Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration from the control care Staff #1. [W 436]		VIT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		1, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC DATE DISTRICT OF COLUMBIA, LLC STATE ZIP CODE 3073 VISTA STREET, NE WASHINGTON, DC 20018		200214		Į			R		
RRDI OF THE DISTRICT OF COLUMBIA, LLC COMPTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PREFEX			09G211	B. Wil	, G		07/0	5/2007	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) (W 342) Continued From page 13 all of her food. There was no intervention observed or overheard. Based on staff performance during the dinner meal, it could not be determined that the direct care staff, overseeing client #1's meal, had been trained to address client #1's rapid eating pace and potential for aspiration. The training record reviewed on May 24, 2007 at approximately 11:30 PM reflected that out of nine direct care staff three direct care staff had received training on May 17, 2006 on detection of signs and symptoms of aspiration. There were no current trained direct care staff. Based on observation, interviews, and the review of training records the facility's nursing services falled to ensure that the direct care staff had been provided training in detecting signs and symptoms of illness or dysfunction for two of three clients in the primary sample. (Client #1 and Client #3) The finding includes: Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the forect Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration to Direct Care Staff #1.			OLUMBIA, LLC		30	73 VISTA STREET, NE			
all of her food. There was no intervention observed or overheard. Based on staff performance during the dinner meal, it could not be determined that the direct care staff, overseeing client #1's meal, had been trained to address client #1's rapid eating pace and potential for aspiration. The training record reviewed on May 24, 2007 at approximately 11:30 PM reflected that out of nine direct care staff three direct care staff had received training on May 17, 2006 on detection of signs and symptoms of aspiration. There were no current trained direct care staff. Based on observation, interviews, and the review of training records the facility's nursing services failed to ensure that the direct care staff had been provided training in detecting signs and symptoms of illness or dysfunction for two of three clients in the primary sample. (Client #1 and Client #3) The finding includes: Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no odocumented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration. There was no odocumented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION	
on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1.	{W 342}	all of her food. The observed or overhed based on staff performeal, it could not be care staff, oversee trained to address and potential for as The training record approximately 11:3 direct care staff the received training or signs and symptom no current trained of training records failed to ensure the provided training in symptoms of illness three clients in the Client #3)	formance during the dinner be determined that the direct ing client #1's meal, had been client #1's rapid eating pace spiration. If reviewed on May 24, 2007 at 80 PM reflected that out of nine ree direct care staff had in May 17, 2006 on detection of ins of aspiration. There were direct care staff. It is not a spiration of the services at the direct care staff had been in detecting signs and its or dysfunction for two of primary sample. (Client #1 and	{W 3	42)				
	{W 436}	on June 5, 2007, a revealed that Direct provided training ir symptoms of aspir documented evide provided training ir symptoms of aspir	at approximately 1:15 PM ct Care Staff #1 had not been in detecting the signs and ation. There was no ince that the nursing staff had in the detecting signs and ation for Direct Care Staff #1.	{W ·	4 36}				

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{W 436}	The facility must furand teach clients to choices about the chearing and other and other devices interdisciplinary teach. This STANDARD	rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces,	{W 4	36}			
	review, the facility were provided with equipment, for two sample. (Client #2) The findings include the facility failed to	failed to ensure that clients necessary adaptive of four clients included in the 2, #4)					
	Client#4 revealed Review of Client # 5/24/07 at approxi Psychological Ass assessment docur recommendations stimulations tools environment throu with the House Marevealed that Clien stimulations tools, stimulation tools, the surveyor with mini bubbles, the sensory, and high	nd attempts to interview the that the client was non verbal. 4's habilitation records on mately 3:50 PM revealed essment dated 11/30/06. The mented that given the following, "Promote use of sensory and exploration of her gh touch and smell". Interview anager on 5/23/06 at 4:03 PM at #4 has several sensory When asked to see the he house manager presented a sensi- ball switch, vibrating gooshy switch, oval tax multimusic vibration enabling device ed batteries. Further interview		1_	(W436) Home Manager has been in-serviced o sensory stimulation tools maintenance pertaining to keeping adaptive equipm repair. In addition, the management st care staff have been in-serviced on Equipment Checklist to be completed dail	e and repair nent in good aff and direct the Adaptive	7/5/07 & Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2007 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC CX41ID SUMMARY STATEMENT OF DEFICIENCIES TAGS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH OBFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGS Continued From page 15 With the house manager revealed that tools have been without operating batteries for over a month. Therefore, the stimulation tools was not available for the client's use. 2. The facility failed to provide client #2 with functional sensory stimulation equipment. Refer to W249. Based on observation, interview, and record review, the facility failed to ensure that clients were provided with the necessary adaptive equipment, for two of four client stinulation to standard the individual of the sample. (Client #2 and Client #4) The finding includes: On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Resident #2 and Resident #4 had been provided with the necessary adaptive		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER HRDI OF THE DISTRICT OF COLUMBIA, LLC X41 ID SUMMARY STATEMENT OF DEFICIENCIES TAGK TAGK						·	R	
HRDI OF THE DISTRICT OF COLUMBIA, LLC 3073 VISTA STREET, NE				B. VVIII	<u> </u>		07/05	5/2007
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) (W 436) Continued From page 15 with the house manager revealed that tools have been without operating batteries for over a month. Therefore, the stimulation tools was not available for the client's use. 2. The facility failed to provide client #2 with functional sensory stimulation equipment. Refer to W249. Based on observation, interview, and record review, the facility failed to ensure that clients were provided with the necessary adaptive equipment, for two of four clients included in the sample. (Client #2 and Client #4) The finding includes: On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Resident #2 and Resident #4 had been provided with the necessary adaptive			OLUMBIA, LLC		30	073 VISTA STREET, NE		
with the house manager revealed that tools have been without operating batteries for over a month. Therefore, the stimulation tools was not available for the client's use. 2. The facility failed to provide client #2 with functional sensory stimulation equipment. Refer to W249. Based on observation, interview, and record review, the facility failed to ensure that clients were provided with the necessary adaptive equipment, for two of four clients included in the sample. (Client #2 and Client #4) The finding includes: On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Resident #2 and Resident #4 had been provided with the necessary adaptive	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
equipment to maintain or enhance their functional skill levels.	{W 436}	with the house man been without opera Therefore, the stim for the client's use. 2. The facility failed functional sensory to W249. ***********************************	rager revealed that tools have ting batteries for over a month. ulation tools was not available d to provide client #2 with stimulation equipment. Refer **********************************	{W 4		pertaining to keeping adaptive equipmerepair. In addition, the management starcare staff have been inserviced on the	and repair ent in good iff and direct	

Health R	egulation Administra	ation	<u> </u>	 -			
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTIP A. BUILDING B. WING	COMPLI) DATE SURVEY COMPLETED R 07/05/2007	
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{1 000}	22, through May 2 three clients was in residential populat additional client was focus. All clients in profound mental residential diagnosis of the psychiatric diagnosis prescribed. The climited to no skills The findings of the at the facility and at both the facility and at both the facility clinical, medical, a include the facility policies. ***********************************	vey was conducted f 4, 2007. A random so nitially selected from ion of six females. A as added to the sam in the sample had dis- etardation. Two of the olindness and three of ses for which medic consumers in this fact in verbal communications. It is and day programs, staff and day programs, and administrative re- its unusual incident re-	sample of a An ple as a agnoses of the clients had ations. Subservations interviews review of the cords to reports and depart 1, acilities in different conducted a focused on state verning rotections. The cord the conducted a focused on state verning rotections and the conducted and the conducted are the conducted ar				
	gulation Administration ORY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRE	SEMERTIVERS	MATURE O	Abuetil _	1/10	(X6) DATE

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{1 000}	Continued From pa	ige 1		{1 000}			
	findings are based nursing and admini records; including in incidents was also	on interviews with restrative staff. Review nvestigations of unus conducted.	v of sual				
{I 052}	3502.10 MEAL SEF	RVICE / DINING ARE	EAS	{1 052}			
	tables, chairs, eatin	l equip dining areas v g utensils, and dishe ne developmental ne	s				
	The findings include During the dinner o 22, 2007 at approxi	bservation conducted imately 6:20 PM, all c	d on May clients		QMRP, with OT has reviewed and assess #1 and Resident #2 habilitation report alternating use of other utensils besides spo and Occupational Therapist will review quarterly regarding using eating uter mealtimes. All staff have been incouraging residents to use other eating uter the property of the prop	to include bons, QMRP client needs asils during serviced on tensils unless	7/17/07 & Ongoing
	was no encouragen utensils as appropri habilitation reports	spoons to eat with. The spoons to eat with the spoons to utile iate. Clients #1 and the spoons of learning or learning spoons.	ize other #2's ese		otherwise indicated through assessm mealtimes. QMRP and Home Manager weekly mealtime observations to asses capabilities in using either eating uten spoons.	will conduct	
	******************	**************************************	*****				
	The finding includes	s:				ļ	
	approximately 6:15 clients were only pr	dinner meal on July t PM revealed that all ovided spoons to eat here was no encoura	of the with				

for the residents to utilize other utensils as appropriate. Resident #1 and Resident #2's

habilitation reports did not reflect that these residents were incapable of using or learning to use utensils other than spoons.

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Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 09G211 07/05/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAĢ DEFICIENCY) {1 090} {I 090} Continued From page 2 {I 090} 3504.1 HOUSEKEEPING {1 090} The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. 1090 Home Manager has submitted work order to have mold 7/5/07 removed from second floor bathroom. As an assurance. This Statute is not met as evidenced by: all home managers have a Maintenance Checklist that is conducted weekly, monthly as well as a daily walk-The findings include: through is performed for maintenance issues in all facilities. During the environmental inspection on May 24. 2007 at 9:35 AM, the surveyor recognized that excessive molding was found on the window ceil and around the window casing of the second floor bathroom. ******* The finding includes: During the environmental inspection on July 5. 2007 at approximately 10:00 AM it was revealed that excessive mold was still present around the window casing of the second floor bathroom. Interview with the House Manager on July 5. 2007 at approximately revealed that the maintenance employees had not removed the mold around the window casing of the second floor bathroom. There was no documented evidence that a work order had been submitted for the maintenance employees to remove the mold around the window casing of the second floor bathroom. {I 209} 3509.9(a) PERSONNEL POLICIES {1 209}

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/05/2007 09G211 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {1 209} {1 209} Continued From page 3 Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of 1209 the following: HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of 7/17/07 & (a) Child or resident abuse or abuse of someone where the employees lived or worked. All background Ongoing checks will be conducted before employees are placed under his or her care and supervision; in any HRDI facility to include "child or resident abuse or abuse of someone under his or her care and This Statute is not met as evidenced by: supervision". The findings include: Personnel records were reviewed on May 24. 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences. ****** The finding include: Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police clearences. {I 210} 3509.9(b) PERSONNEL POLICIES {1 210} Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of I210 the following: HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of where the employees lived or worked. All background (b) Neglect; 7/17/07 & checks will be conducted before employees are placed Ongoing in any HRDI facility to include "neglect". This Statute is not met as evidenced by: The findings include: Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made

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The finding include:

not containe police clearences.

Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police

Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did

clearences.

(I 391) 3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS

Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R B. WING 07/05/2007 09G211 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {1 391} {| 391} Continued From page 6 necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine: This Statute is not met as evidenced by: The findings: 1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment date September 19, 7/5/07 1. a) Nurse has obtained results from Client #1's GYN 2006 reflected diagnoses to include hypertension consultation held on July 11, 2006. The Nurse will ensure that all results are obtained from consultations in and history of carcinoma of left breast, left breast a timely manner. mastectomy. b) The facility Nurse has scheduled Client#1 for a. According to a GYN consultation dated July mammogram for June 11, 2007 and will ensure that all 7/11/07 & recommended consultations are conducted within a 11, 2006, client #1 allowed a small sample Ongoing specific timeframe which does not interfere with the obtained for the culture since the client "did not client's health, safety and welfare. allow brushing of the cervix". The document reflected that if the sample was not adequate then the procedure would need to be repeated. Prior to this examination, another exam had been attempted March 2005; however, it was unsuccessful. The primary physician's note dated August 16, 2006 reviewed at 3:48 PM reflected "annual exam, pap done, results pending". At the time of the survey, the result were not available and the physician had not made further reference to the results in follow up monthly notes. b. According to client #1's mammogram report dated March 27, 2006, the client was to have a return visit in twelve months. At the time of the survey, the annual mammogram had not been done. The surveyor and Registered Nurse (RN)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED R 07/05/2007		
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{ 391}	(EACH DÉFICIENCY MUST BE PRECÉDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(1 391)	3. QMRP has, since survey, obtain from the Speech and Language Path #3 whereby the Eating Guidel implemented to include choking prevention plan. All staff have be eating guidelines which indicate we provide intervention to promote a s SLP and QMRP will ensure quarconducted to assess client needs.	hologist for Clie lines have bed and aspiration cen in-serviced of where staff shou lower eating pac	nt en 7/16/07 on on ald ee.	
	to ensure medical p	record review, the fac preventive and gener gh timely appointmer	al					

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B, WING 09G211 07/05/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3073 VISTA STREET, NE HRDI OF THE DISTRICT OF COLUMBIA, LLC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {I 391} Continued From page 10 {I 391} follow up for one of three residents in the primary sample. (Resident #1 and Resident #3) The findings include: 1. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:45 PM revealed that the results of Resident #1's annual pap exam dated July 11, 2006 had not been 1391 obtained. There was no documented evidence Nurse has obtained results from Client #1's GYN that the facility had obtained the client's pap consultation held on July 11, 2006. The Nurse will ensure that all results are obtained from consultations in exam results 7/5/07 a timely manner 7/16/07 & 2. Interview with the Licensed Practical Nurse Ongoing (LPN) on June 5, 2007, at approximately 1:15 PM Nurse has provided in-service training to all staff regarding signs and symptoms of illness. As well revealed that Direct Care Staff #1 had not been Quality Improvement Specialist conducts monthly provided training in detecting the signs and trainings which include Signs and Symptoms of illness. symptoms of aspiration. There was no Nurse in the facility will ensure in-service trainings are documented evidence that the nursing staff had conducted quarterly and on an as needed basis such that client care is assured. provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1. {I 395} 3520.2(e) PROFESSION SERVICES: GENERAL {1 395} **PROVISIONS** Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by:

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training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their

environments and to achieve their optimum levels

of physical, mental and social functioning.

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{ 420}	Continued From page 12			{1 420}		· ·			
	This Statute is not The findings includ								
	1. Client #2's IPPs records were review AM.								
	According to client program that read 'language skills by the opportunities wo feel snack times were 2007 at approximationner meal on May 6:10 PM. There we have client #2 to sign opportunities.		1.	I420 Client #2's IPP has, since survey, beer staff such that the program plan is language skills" will be implemented obasis. QMRP will ensure staff re training on all individuals' IPP to pronactive treatment process within the facility. Client#2's Sensory stimulation program has been reviewed with the staff.	ram plan for "expressive uplemented on a continuous tree staff receive quarterly IPP to promote continuous thin the facility. tion program, since survey,				
	2. During the obse 2007, client #2 was impaired. The Hou client #2 was blind. included on the Me January 23, 2007 tl 2007 at 6:00 PM.			services staff on proper implementation of this particular program to include affording Client #2 the opportunity to engage in multi-sensory stimulation activities of her liking and that will enhance her other sensory skills.		is ne on			
	The psychological a 2007 that was revie PM reflected that the to participate in ser sound, smell, tast, the "it would be held her senses".								
	Manager indicated was in the facility. included a sensi- bubbles, gooshy sw	at 4:03 AM, the House that sensory motor e The equipment show all switch, vibrating m witch, oval tax multi s ration enabling device	equipment vn nini ensory,						

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